FREQUENTLY ASKED QUESTIONS AND RESPONSES
ABOUT THE FEE CALCULATION FOR HEALTH CARE CLAIMS ASSESSMENT (HCCA) & HEALTH INFORMATION TECHNOLOGY ASSESSMENT (HIT)

(For additional information, *see* 8 V.S.A. § 4089l and 4089k)

- ***How is a "Vermont member" defined?***
  Response: A Vermont member must have a Vermont zip code. Federal employees' claims (*e.g.*, homeland security) with a Vermont zip code, however, are not included.

- ***Should we include claims of only those members who are covered by a VT product?***

  Response: No, claims of Vermont members are included regardless of where the product is offered or purchased. The surcharge applies to insurers with a monthly average enrollment of 200 or more Vermont members.

- ***In NY, the HCRA surcharge applies to all claims where the place of service is in NYS. Is the fee meant to apply to all claims where the service occurred in the state of VT?***

  Response: The fee applies to all services for Vermont members, regardless of where the service is provided. For example, claims for Vermont members receiving services at Dartmouth Hitchcock are included. Conversely, the fee does not apply to services provided in Vermont to non-Vermont members; for example, medical claims for someone from New York State who received medical or pharmacy services at Fletcher Allen should not be included.

- ***Does Catamount qualify as a "state health care assistance program financed in whole or in part through a federal program," so that the fee is not applicable?***

  Response: No. Catamount Health is considered an individual health care benefit policy offered by participating health care insurers to eligible Vermont residents, and claims under Catamount Health are therefore included by participating insurers when calculating the fee.

- ***Does Medicare Supplement qualify as "limited benefit health insurance" so that the fee is not applicable?***

  Response: No. Medicare Supplement is not considered "limited benefit health insurance" and claims under Medicare Supplement should be included when calculating the fee.

- ***How will the paid claims data set produced by the Vermont Healthcare Claims Uniform Reporting & Evaluation System (VHCURES) be used as the basis for the annual fee calculation?***

Health Care Claims Assessment:

Response: The consolidated VHCURES paid claims data set will be used as the basis for the annual calculation of paid claims by insurer, including third party administrators (TPAs) and pharmaceutical benefits managers (PBMs) providing services to Vermont residents in the lines of business subject to the fee. The resulting report is the "Annual HCCA Fund Surcharge Report." As with the fee, VHCURES includes a reporting threshold of 200 covered Vermont lives and includes the same universe of insurers as those subject to the surcharge. The law provides:

- Beginning November 1st, 2011 and annually thereafter, each health insurer shall pay an assessment into the state health care resources fund established in 33 V.S.A. § 1901d in the amount of 0.80 of one percent of all health insurance claims paid by the health insurer for its Vermont members in the previous fiscal year ending June 30. The annual fee shall be paid in installments on November 1st, January 1st, April 1st, and June 1st.

8 V.S.A. § 40891(a)(1).

In addition, a health insurer that fails to timely pay the assessment may be subject to sanctions which include an administrative penalty of not more than $1,000 for each violation. *See* 8 V.S.A. § 40891(d).

As with all insurers, Medicare Supplement insurers must submit quarterly payments on the same annual schedule. Since VHCURES only requires that Medicare Supplement insurers submit a subset of claims, Medicare Supplement insurers are required to self-report annual paid claims total based on the entire universe of paid claims for Vermont Medicare Supplement enrollees. BISHCA will use other administrative data sources to check the self-reported paid claims basis of Medicare Supplement insurers.

Health Information Technology Assessment:

Response: Like the HCCA, the VHCURES consolidated paid claims data set will be used as the basis for the annual calculation of paid claims by insurer, including TPAs and PBMs providing services to Vermont residents in the lines of business subject to the fee. The resulting report is the "Annual HIT Reinvestment Fund Surcharge Report." As with the fee, VHCURES includes a reporting threshold of 200 covered Vermont lives and includes the same universe of insurers as those subject to the surcharge.

The Annual HIT Reinvestment Fund Surcharge Report, required to be published on an annual basis by October 1st is based on the most recent fiscal year spanning July1 through June 30. The assessment is calculated as 0.199 of one percent of the insurer's paid claims amount. The basis for the annual report is For the annual payment cycle starting with the first quarterly payment due November 1, BISHCA will publish an initial report by October 1st of each year

Since this is the first year of VHCURES data collection, there are insurers who have submitted data on a delayed basis and those who have not submitted the required data at all. BISHCA anticipates that the October 1st update will result in a more complete report capturing late reporters. As compliance with VHCURES reporting requirements improves over time, BISHCA anticipates that the Annual HIT Reinvestment Fund Surcharge Report published will be more complete and reflective of Vermont's health insurance market.

Insurers subject to the surcharge whose information is not reflected in the Annual HIT Reinvestment Fund Surcharge Report must self-report the quarterly paid claim basis for the November 1st payment based on the prior fiscal year paid claims total (July 1st through June 30th). If the self-reported paid claims total is lower than the total subsequently calculated based on actual data submitted to VHCURES, the insurer is required to promptly submit any additional amount due.

As with all insurers, Medicare Supplement insurers will submit quarterly payments on the same annual schedule of November 1st, January 1st, April 1st, and June 1st. Since VHCURES only requires that Medicare Supplement insurers submit a subset of claims, Medicare Supplement insurers are required to self-report annual paid claims total based on the entire universe of paid claims for Vermont Medicare Supplement enrollees. BISHCA will use other administrative data sources to check the self-reported paid claims basis of Medicare Supplement insurers.

Insurers with questions about the Annual HIT & HCCA Reinvestment Fund Surcharge Report can contact Dian Kahn electronically at BISHCA at dian.kahn@state.vt.us.

- ***What happens if an insurer has no surcharge amount listed on the Annual HCCA/ HIT Fund Surcharge Report or if an insurer is listed on the Annual HCCA/HIT Fund Surcharge Report but has not paid the required HCCA/HIT Fund Fee in a timely manner?***

  Response: BISHCA will notify the insurer to come into compliance with VHCURES reporting requirements as soon as possible. Such insurers may be subject to enforcement actions for failing to comply with the reporting provisions of Vermont law.

- ***Is Medicare Part D included when calculating the assessment?***

  Response: No. Federal law preempts states from imposing a tax or assessment on claims paid by a Medicare Part D plan. *See* Sec. 1860D-12(g) of the Medicare Modernization Act. *See also* 42 C.F.R. Sec. 423.440(b).

- ***Are Medicare Parts A & B are included when calculating the assessment?***

Response: No. Medicare Parts A and B are federally administered and therefore not subject to the surcharge.

- ***Many of our college student policies (comprehensive policies) are not primary coverage, have limited scheduled benefits, and relatively low maximums for accident and sickness. Are they included in the calculation?***

  Response: Yes, comprehensive student polices should be included student policies for stand-alone benefits only (such as vision or dental) should not be included.

- ***Are capitated claims excluded since no payment is issued on the actual claim? Are the capitation payments to the providers excluded?***

  Response: Yes. Capitation payments are included when in the calculation. Note that the surcharge amount calculated by the State for comprehensive major medical benefits (including comprehensive student policies) is based primarily on the VHCURES paid claims data submitted by insurers including carriers, TPAs, and PBMs. VHCURES does not include capitation payments. Beginning November 1, 2011 and annually thereafter, each health insurer shall pay an assessment into the state health care resources fund established in 33 V.S.A. § 1901d in the amount of 0.80 of one percent of all health insurance claims paid by the health insurer for its Vermont members in the previous fiscal year ending June 30.

- ***Should the withhold be included or excluded from the calculation?***

  Response: Yes. The withhold is included when calculating the fee.

- ***Should re-insured claims (e.g., organ transplants, high cost claims, etc.) be included in the calculation?***

  Response: Yes. For purposes of calculating the HCCA fee, the paid claims total includes the total losses incurred before the reinsurer offers a recovery at either the aggregate or individual member levels.

- ***Should co-payments, deductibles, and coinsurance be included in the calculation?***

  Response: No. They are excluded from the fee calculation because the health insurer does not pay them.

- ***Are dental claims included in the calculation?***

  Response: It depends. All claims paid under comprehensive medical insurance plans are included in the fee calculation, including riders to the plan wherein members are receiving dental benefits in addition to comprehensive medical benefits. This includes, for example, pharmacy claims, claims paid under riders expanding dependent coverage to ages over 18, dental claims paid under the preventive health

and traumatic injury provisions of medical insurance. Dental claims paid under a separate dental policy, however, are excluded.

- ***Are vision claims included in the calculation?***

  Response: Vision claims processed through the core contract or as part of the benefit package for comprehensive major medical plans should be included. Like dental claims, stand-alone limited benefit plans for vision are excluded.

- ***Where can I find the annual surcharge report?***

  Response: The Annual HCCA/HIT Fund Surcharge Report is available at: www.hcr.vermont.gov/improve_quality/healthcare_IT_fund.

- ***Does the assessment apply to group stop loss coverage issued to an employer in connection with the employer's self funded employee medical plan?***

  Response: Stop loss insurance is a form of reinsurance that an insurer purchases to cover claims that exceed thresholds of specified dollar amounts for either an individual or insured group. Stop loss insurers are not subject to the paid claims assessment.

- ***Is there a contact to assist with questions about Quarterly Fee Submissions or the Annual HCCA Fund Surcharge Report?***

  Response: Yes. Contact Dian Kahn at BISHCA (dian.kahn@bishca.state.vt.us) with questions about the calculation of the fee, or Mylinda Trombley mylinda.trombley@ahs.state.vt.us) with questions about payment invoicing or receipt.

- ***Will statutory language change to reflect an alignment of a payment schedule for both assessments?***

  Response: Yes. The statute will be changed to align the payment schedule of both assessments.

- ***As a provider, can I pay my entire year's assessment or both assessments in one lump sum?***

  Response: Yes. Providers can pay the entire year's HIT and HCCA assessments in one lump sum as long as it is clearly denoted. A provider may also pay the full annual obligation of both funds in one lump sum, as long is it is clearly documented.